STATEMENT OF SUPERINTENDENT DISABILITY BENEFITS APPLICATION

State Form 17295 (R2/2-02)
Approved by State Board of Accounts 2002

Indiana State Teachers' Retirement Fund
150 West Market St. Suite 300
Indianapolis, IN 46204-2809
Telephone: (317) 232-3860/ Toll Free: (888) 286-3544
Fax: (317) 232-3882
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PRIVACY NOTICE

Your Social Security Number is requested by this state agency in order to meet requirements of IRS Code 3405. Disclosure is mandatory; this form will not be processed without it.

INSTRUCTIONS: This form must be on file at ISTRF prior to applicant being considered for disability benefits.

APPLICANT INFORMATION
(Applicant to complete and deliver to his/her superintendent)

Social Security Number	TRF Number	
Name of Applicant	Street Address	
City	State	Zip Code

SUPERINTENDENT'S STATEMENT
(Superintendent to complete and return to ISTRF)

1. I have personally known the applicant for:	2. Applicant has been under my supervision for:

3. Information, to my personal knowledge, concerning applicant's physical condition:

4. In my opinion, applicant is incapacitated for duty as a teacher. (circle one) YES NO	5. Applicant is under contract to our school corporation. (circle one) YES NO

Please read the following carefully prior to completing questions 6, 7, and 8.
* Compensation includes all sick leave pay received by this applicant from your school corporation . When furnishing the dates below, please list the name of the month; do not refer to any month by designating a number. It is important that the dates below are accurate.

6. Date* compensation ceased (month, day, year)	7. Date applicant last taught (month, day, year)	8. The semester in which this teacher last taught ended: (month, day, year)

9. What is your opinion on whether or not the applicant should be granted a disability pension?

Comments:

Name of school unit

Signature of superintendent	Date signed

Name and title if other than Superintendent